

**APPLICATION FOR CLINICAL LABORATORY SCIENTIST OR
LIMITED SCIENTIST LICENSE**

Instructions: Application Fee: \$ 97.00

**DO NOT WRITE IN THIS BLOCK
FOR DEPARTMENTAL USE ONLY**

1. Please complete this application in full. An incomplete application will be returned to the applicant for completion.
2. Your nonrefundable money order, cashier's check, or personal check application fee must be submitted and made payable to:

CPS Human Resource Services
Attn: CLS Program
241 Lathrop Wy
Sacramento, CA 95815

3. All Official Transcripts, U.S. armed service documents, and verification of clinical Laboratory training/experience must be sent by the registrar's office, the U.S. armed Service office, the laboratory director, or the training coordinator, directly to this Department at the following address. For those categories requiring board certification written examination, please contact your board and have the board submit verification directly to the Department at the following address: California State Department of Health Services, Laboratory Field Services, 1111 Broadway – 19th Floor, Oakland, CA 94607-4036.

4. Check ONE license category only. An applicant can only apply for one category per each exam cycle

- | | |
|---|---|
| <input type="checkbox"/> 01 Clinical Laboratory Scientist | <input type="checkbox"/> Clinical Histocompatibility Scientist ✱ |
| <input type="checkbox"/> 05 Clinical Hematologist Scientist | <input type="checkbox"/> Clinical Cytogeneticist Scientist ✱ |
| <input type="checkbox"/> 06 Clinical Chemist Scientist | <input type="checkbox"/> Clinical Genetic Molecular Biologist Scientist ✱ |
| <input type="checkbox"/> 07 Clinical Immunohematologist Scientist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> 08 Clinical Microbiologist Scientist | See note below ✱ |
| <input type="checkbox"/> 09 Clinical Toxicologist Scientist | |

Examination Number		Examination Date	
DO NOT WRITE IN THIS SPACE			
Approval	By	Date	
<input type="checkbox"/>	Final	_____	_____
<input type="checkbox"/>	Contingent	_____	_____
<input type="checkbox"/>	Reject	_____	_____
Reason _____			
<input type="checkbox"/>	Approved Temporary License Temporary License No. _____		
Training: <input type="checkbox"/>		Issued: _____	
Qualifying Experience			
<input type="checkbox"/> California		<input type="checkbox"/> U.S.	<input type="checkbox"/> Other
Exam:	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Did not appear
Repeat: <input type="checkbox"/>			
Permanent License No.		□□□□□	
Previous File I.D. No.		□□□□□	
Site Code		□□	
Geographical Location		□□	

5. Please Print: Last Name

First Name & Middle Initial

Mailing Address: (Street or P.O. Box)

City

County

State/Country

Zip

6. For those categories that require a written state administered examination. I prefer to take the examination in:

☐ Southern California

☐ Northern California

7. Sex

☐ Male

☐ Female

8. Birth Date (month/day/year)

___/___/___

9 Place of Birth

10. Maiden name or previous last name

11. Mother's Maiden Name

12. United States Social Security Number*

13. Citizen of U.S.

☐ Yes ☐ No

15. Have you previously applied for a California Scientist Examination?

☐ Yes ☐ No If yes, name used and date _____

16. Have you been issued another California laboratory personnel license (including trainee license)?

☐ Yes ☐ No If yes, type of license _____ License Number _____

17. Have you been convicted of any felonies or misdemeanors other than minor traffic violations?

☐ Yes ☐ No If yes, attach statement giving details.

18. Education (Ask College or university to send official transcripts **Directly To LFS.**)

Name of College or University	State	Country	Major Courses of Study	From Month/Year	To Month/Year	Degree/Date Conferred	Number of Units

19. ☐ I have requested that my transcript be sent Directly to LFS from my College/University. Date requested: _____

✱ California does not offer a state administered written examination in these categories. A National Certification Board Examination as required by regulations for the category selected must be passed before applying for a California License.

20. ☐ Yes, I have completed _____ months of Clinical Laboratory Training as a Clinical Laboratory Scientist (technologist) trainee.
21. ☐ Yes, I have completed _____ months of Clinical Laboratory Experience as a Clinical Laboratory Scientist (technologist).
22. ☐ Yes, I have completed _____ months of Board Certified Laboratory Training.
23. Chronological listing of institutions of training and/or experience as a CLINICAL LABORATORY SCIENTIST (not technician or laboratory assistant).

TRAINING: Check each box to show phases of training received in each area. If currently in training, give estimated date of completion.

EXPERIENCE: Check each box to show experience in each area. Record hours per week to represent the work week, e.g., 20 hrs., 40 hrs., etc.

Laboratory – <u>Internship/Training</u>	Hours per week	Dates		(Check One or More)	
		From	To		
Address (number, Street)				<input type="checkbox"/> Bacteriology <input type="checkbox"/> Chemistry <input type="checkbox"/> Genetics <input type="checkbox"/> Molecular Biology <input type="checkbox"/> Hematology <input type="checkbox"/> Histocompatibility <input type="checkbox"/> Immunohematology	<input type="checkbox"/> Parasitology <input type="checkbox"/> Serology/immunology <input type="checkbox"/> Toxicology <input type="checkbox"/> Urinalysis
City State Zip code					
Laboratory – <u>Internship/Training</u>	Hours per week	Dates		(Check One or More)	
		From	To		
Address (number, Street)				<input type="checkbox"/> Bacteriology <input type="checkbox"/> Chemistry <input type="checkbox"/> Genetics <input type="checkbox"/> Molecular Biology <input type="checkbox"/> Hematology <input type="checkbox"/> Histocompatibility <input type="checkbox"/> Immunohematology	<input type="checkbox"/> Parasitology <input type="checkbox"/> Serology/immunology <input type="checkbox"/> Toxicology <input type="checkbox"/> Urinalysis
City State Zip Code					
Laboratory – <u>Experience</u>	Hours per week	Dates		(Check One or More)	
		From	To		
Address (number, Street)				<input type="checkbox"/> Bacteriology <input type="checkbox"/> Chemistry <input type="checkbox"/> Genetics <input type="checkbox"/> Molecular Biology <input type="checkbox"/> Hematology <input type="checkbox"/> Histocompatibility <input type="checkbox"/> Immunohematology	<input type="checkbox"/> Parasitology <input type="checkbox"/> Serology/immunology <input type="checkbox"/> Toxicology <input type="checkbox"/> Urinalysis
City State Zip code					
Laboratory – <u>Experience</u>	Hours per week	Dates		(Check One or More)	
		From	To		
Address (number, Street)				<input type="checkbox"/> Bacteriology <input type="checkbox"/> Chemistry <input type="checkbox"/> Genetics <input type="checkbox"/> Molecular Biology <input type="checkbox"/> Hematology <input type="checkbox"/> Histocompatibility <input type="checkbox"/> Immunohematology	<input type="checkbox"/> Parasitology <input type="checkbox"/> Serology/immunology <input type="checkbox"/> Toxicology <input type="checkbox"/> Urinalysis
City State Zip Code					

If more space is required, please attach a separate sheet(s).

I declare under penalty of perjury that all information provided in this application are true and correct. I agree and understand that any misstatements of material facts will cause forfeiture on my part of all rights under the laws of California relating to clinical laboratories.

Signature of applicant	Date
Daytime telephone ()	E-mail address (if applicable)

NOTE:-Allow at least 10 weeks for processing of the application. The processing time is based upon receipt of the fully completed application and official documents, as required by Laboratory Field Services

*PRIVACY STATEMENT

On January 1, 1977, the Governor's Executive Order # B-22-76 became operational. This order is intended to protect the privacy of individuals by regulating the gathering and maintenance of personal data. The item relating to citizenship and ethnicity appearing on this form is voluntary and need not be completed; all other items are mandatory and the information requested must be furnished. Mandatory information is used to identify an applicant properly and to determine an individual's eligibility for licensure as authorized under the provisions of Chapter 3, Division 2, of the Business and Professions Code and Chapter 2, Title 17, of the Administrative Code. Failure to provide such information would preclude acceptance of your application. You have the right to review your file which is maintained by: Chief, Laboratory Field Services, Department of Health Services, 1111 Broadway – 19th floor, Oakland, CA 94607-4036.